STATE OF CALIFORNIA BUSINESS TRANSPORTATION AND HOUSING AGENCY

DEPARTMENT OF CORPORATIONS, HEALTH CARE DIVISION, COMPLAINT FORM

PLEASE READ THE INSTRUCTION SHEET PRIOR TO COMPLETING THIS FORM. PLEASE TYPE OR PRINT CLEARLY AND COMPLETE ALL ITEMS ON THIS FORM.

1. Your full name (identifies you as the complainant):

_____

2. Your street address (residence): _____
   City: _____ State: _____ Zip: _____
3. Telephone: Home ( ) _____
   Work ( ) _____

4. Complete Name of Health Plan: _____

_____

5. Address: _____ _____

   City: _____ State: _____ Zip: _____

6. Subscriber's complete name if different from your name:

_____

7. Subscriber's identification number:

_____

8. If group coverage, name of group:

_____

9. Have you previously written to the Department of Corporations about this specific matter? If yes, please give:
   File number: _____ Date Written: _____

10. Have you reported this to other governmental agencies?
    Yes____ No____

    If yes, please state name of agency and its file number:

_____

_____

10a. Are you a Medi-Cal beneficiary? Yes___ No___
     Are you a Medicare beneficiary? Yes___ No___

11. Do you have an attorney representing you? Yes___ No____

12. Is there a civil action (lawsuit) pending? Yes___ No____
If yes, state the name of the county, case number, date filed: _____

_____
* Please also attach a photocopy of the court documents.

13. Have you contacted the health plan complained about?
Yes____ No___
If yes, state the date(s) and person(s) contacted: _____

_____

14. Do you know whether the health plan has a grievance system?
Yes____ No____
If yes, have you used it? Yes____ No____

15. This information provided is furnished voluntarily. I understand it is not mandatory that I furnish the requested information, but failure to do so may delay or even preclude further consideration of my complaint.

16. I understand that a copy of this complaint may be sent to the health plan.

17. Stated as briefly as possible, t he following are the essential facts (including, "who, what, where, when and how) of my complaint (use additional paper if needed):
_____

_____

_____

Date:_____Signed: _____
If you have any questions concerning this form, please call our toll free number 1-(800)-400-0815.

After you complete the for m and attach a photocopy of all of the documents and records, please mail them to:

Department of Corporations
Health Care Division
Consumer Services Representative
3700 Wilshire Boulevard
Los Angeles, CA 90010-3001